A beneficiary eligible for Medi-Cal also may have OHC. In most circumstances, OHC must be billed prior to billing Medi-Cal. Refer to the *Other Health Coverage (OHC) Codes Chart* section in this manual for additional information. For information about billing Medi-Cal after billing the Other Health Coverage, refer to the *Other Health Coverage (OHC)* section in the Part 2 manual.

Cost-Avoided OHC and HMO Coverage Codes

If a recipient's OHC code is one of the following and the service rendered falls within the recipient's COV under the OHC, the provider must refer the recipient to the HMO or bill the OHC before billing Medi-Cal.

OHC Code	Carrier
B	Blue Cross of California
C	Champus (HMO)
D	Prudential
E	Aetna
F	Medicare HMO
G	General American
H	Mutual of Omaha
I	MetraHealth
J	John Hancock Mutual Life Insurance
K	Kaiser (HMO)
P	PHP/HMO
Q	Undefined
R	Undefined
S	Blue Shield of California
T	Travelers Plan Administrators (only)
U	CIGNA/Connecticut General/Equicor
V	Coverage other than those specified (variable)
W	Great West Life Assurance Co.
2	HealthSource Provident Administrators
3	Principal Financial Group/Principal Mutual
4	Pacific Mutual Life Insurance
5	First Health/Alta Health
6	American Association of Retired Persons (AARP)
7	Undefined
8	New York Life Insurance
9	Healthy Families (HF) Program

Unless a provider is an authorized provider of a recipient's health plan, refer recipients with HMO coverage to the plan for covered treatment, or contact the HMO for treatment authorization.

Medi-Cal is not liable for the cost of HMO-covered services if the recipient elects to seek services from a provider not authorized by the HMO. To establish Medi-Cal's liability, the provider must obtain an acceptable denial letter from the HMO. For additional information, refer to "HMO Denial Letters" in the *Other Health Coverage (OHC)* section of the Part 2 manual.

**Non-Restricted
OHC Codes**

Providers are encouraged, but not required, to bill the OHC carrier prior to billing Medi-Cal if the response from the Medi-Cal eligibility verification system is one of the following non-restricted OHC codes:

OHC Code	Carrier
A	Any carrier
M	Multiple coverage (recipient has more than one insurance policy)
X	Blue Shield of California
Y	Undefined
Z	Blue Cross of California

The OHC carrier may reimburse at a higher rate than Medi-Cal. If a provider receives a partial payment from the OHC carrier, Medi-Cal may be billed for the balance. Medi-Cal reimbursement is the difference between the Medi-Cal allowable amount and the OHC carrier payment.

**OHC Code "A" – Outside
HMO Service Area**

Medi-Cal recipients who have HMO coverage but reside outside the service area of the HMO also are assigned OHC code "A." Providers may bill Medi-Cal directly for these services without first obtaining a denial from the HMO. However, since most HMOs cover out-of-area emergency care, providers are required to bill the HMO for emergency services.

Recipients with an HMO code living outside the HMO service area should contact DHS, Health Insurance Section, at 1-800-952-5294 to have the OHC code changed to "A."

**OHC Code "F" –
From a Medicare HMO**

OHC code "F" identifies Medi-Cal recipients who receive benefits from a Medicare-contracted HMO in lieu of Medicare fee-for-service. Recipients who have Medi-Cal and Medicare HMO coverage must seek medical treatment through the Medicare HMO. Medi-Cal is not liable to pay for HMO-covered services if the recipient elects to seek services from a provider not authorized by the HMO.

Medi-Cal claims for recipients with Medicare HMO coverage are not Medicare/Medi-Cal crossover claims. Therefore, to bill Medi-Cal for services not included in the Medicare HMO plan, submit a Medi-Cal claim accompanied by an Explanation of Benefits (EOB) or denial letter showing that either the Medicare HMO was billed first and partial payment was made or that the Medicare HMO does not cover the service.

OHC Code "L" –
Dental Coverage

OHC code "L" indicates that a recipient has dental coverage only. This code is not applicable to claims billed through EDS.

OHC Code "N" – No OHC

If DHS is unaware that a recipient has OHC, the Medi-Cal eligibility verification will not provide any information with respect to OHC. If the provider identifies that OHC is available, the provider must report this coverage within 60 days to DHS under *California Code of Regulations*, Title 22, Section 51005.

HMO Coverage

Unless a provider is an authorized provider of a recipient's HMO plan, a provider should refer recipients to the HMO for treatment.

State and Federal laws require that all available health coverage be exhausted before billing Medi-Cal. Medi-Cal is not liable to pay for HMO-covered services if a recipient elects to seek those services from a provider not authorized by the HMO.

HMO plans often cover emergency care required until the patient's condition permits transfer to the HMO's facilities. Providers should contact the HMO for emergency treatment authorization and billing instructions.

**Foster Care
Children**

Medi-Cal providers may request the removal of the Other Health Coverage (OHC) indicator from the Medi-Cal Eligibility Data System (MEDS) for foster care children by calling 1-800-952-5294. This policy applies to all children in foster care regardless of the aid code assigned to the child.

The OHC code on the MEDS may be removed upon request if:

- The provider has received written communication or documentation of verbal communication from the other health insurer that confirms the specific provider, service, frequency or location is not covered by the OHC
- The OHC carrier does not supply a written or documentable verbal response within the required 15-day response time, and 15 days have elapsed since the documented request was made by the provider for confirmation of non-coverage

After the OHC indicator has been removed, claims for Medi-Cal benefits may be billed directly to Medi-Cal.

The provider is not required to submit the above documentation to the Department of Health Services (DHS). All documentation of non-coverage should be retained in the foster care child's medical file, as it may be subject to future review by DHS.

Other Health Coverage (OHC) Codes Chart

This section defines Other Health Coverage (OHC) and the coding systems used in connection with billing Other Health Coverage carriers and/or Medi-Cal.

OHC is any non Medi-Cal private health coverage plan or policy that provides or pays for health care services. OHC includes benefits available from the following organizations:

- Commercial health insurance companies
- Prepaid Health Plans (PHPs)
- Health Maintenance Organizations (HMOs)
- Professional associations
- Unions
- Fraternal groups
- Employer/employee benefit plans
- Self-insured and self-funded plans
- Medicare-contracted HMOs or risk plans
- Medicare supplemental policies

The following organizations are not considered OHC:

- Medi-Cal managed care
- Medicare fee-for-service
- Automobile insurance
- Life insurance

Note: Medi-Cal managed care is not OHC. Providers should refer patients enrolled in Medi-Cal managed care plans to the plan for treatment unless the provider is authorized to treat under the plan. Refer to the *MCP: An Overview of Managed Care Plans* section in this manual for more information.

Reporting OHC

State law requires Medi-Cal providers to notify the Department of Health Services (DHS) if they believe a recipient may be entitled to OHC. Call 1-800-952-5294 between 8 a.m. and 5 p.m. to report possible coverage, or write to:

> Department of Health Services
> Health Insurance Section
> P.O. Box 1287
> Sacramento, CA 95812-1287

Be sure to indicate the recipient's name, Medi-Cal Beneficiary Identification Number (BIC) and name of the insurance plan.

Nondiscrimination

Under state law, when a provider obtains proof of eligibility, the provider must accept the Medi-Cal recipient and be bound by the rules and regulations of the Medi-Cal program. Obtaining proof of eligibility includes:

- Verifying eligibility through the Medi-Cal eligibility verification system, or

- Taking a label from a paper card, or

- Taking a photocopy of a paper card

If a provider obtains proof of eligibility that indicates a recipient is eligible to receive services, the provider is not permitted to treat the recipient as private pay because of the recipient's OHC status. However, if the provider does not participate in the recipient's OHC plan, the provider should refer the recipient to the OHC. Medi-Cal is not liable for OHC-covered services <u>if the recipient elects to seek services from a provider not authorized by the OHC.</u>

Eligibility Verification

When requesting eligibility verification for a recipient with OHC, the Medi-Cal eligibility verification system returns a message stating a recipient's Scope of Coverage (COV). COV codes designate the specific service categories covered by a recipient's health coverage. For detailed information, refer to the *Other Health Coverage (OHC) Guidelines for Billing* section in this manual.

**Billing OHC
Before Medi-Cal**

In most situations providers are required by law to exhaust the recipient's OHC before billing Medi-Cal. In those situations where OHC utilization is not required before billing Medi-Cal, providers are still encouraged to bill OHC first (OHC plans often pay more than Medi-Cal).

**Locating Recipient's
OHC Information**

The Medi-Cal eligibility verification system returns a message that includes OHC information, when known. The eligibility verification system is accessed through the Point of Service (POS) device, Automated Eligibility Verification System (AEVS), state-approved vendor software and the Medi-Cal Web site on the Internet at *www.medi-cal.ca.gov.*

**Sample POS
Device Printout**

In the following POS device printout, the OHC portion of the printout (shown in bold) is: OTHER HEALTH INSURANCE COVERAGE UNDER CODE B. SCOPE OF COVERAGE: IOMPVL.

```
        MEDICAL OFFICE
           T999999

           98-06-15
           17:16:36

PROVIDER NUMBER:
GR0000000

TRANSACTION TYPE: ELIGIBILITY
INQUIRY

RECIPIENT ID:
123456789

YEAR & MONTH OF BIRTH:
1966-12

DATE OF ISSUE:
94-02-01

DATE OF SERVICE:
98-03-15

LAST NAME: ROBERTS. MEDI-CAL
RECIP HAS A $00050 SOC. OTHER
HEALTH INSURANCE COVERAGE
UNDER CODE B. SCOPE OF
COVERAGE: IOMPVL.
```

Sample POS Device Printout

Note: A worksheet for recording eligibility information conveyed via telephone, the *Automated Eligibility Verification System (AEVS) Response Log,* is in the *AEVS: Transactions* section of this manual.

POS/AEVS:
Multiple Insurer Messages

If a recipient has reported multiple insurance policies, the Point of Service (POS) network returns a message identifying the name of the other insurance carrier(s). If eligibility is checked via the Automated Eligibility Verification System (AEVS), a carrier code that identifies the insurer is stated. A list of carrier codes is in *AEVS: Carrier Codes for Other Health Coverage* on the Medi-Cal Web site at *www.medi-cal.ca.gov.*

OHC Code
Explanation

In the POS device printout sample on the previous page, *"OTHER HEALTH INSURANCE COVERAGE UNDER CODE B"* means that this recipient has Blue Cross insurance. This is the Other Health Coverage (OHC) code. This code tells you the name of the plan that provides the recipient with health care. Other insurance companies or HMOs have different codes. Refer to the OHC and COV Code Charts on the following pages for a listing of these codes.

COV Code
Explanation

In the POS device printout sample on the previous page, *"IOMPVL"* means that this recipient's Blue Cross insurance covers inpatient, outpatient, medical and allied, pharmacy, vision, and long term care services. These are the Scope of Coverage (COV) codes. Each recipient's plan differs. Each COV code indicates a different set of services.

If information about a recipient's insurance COV is not available to DHS, the message "COMPREHENSIVE" is returned from the Medi-Cal eligibility verification system. This message indicates coverage for all medical services except long term care and dental. Providers must bill the insurance carrier for all other services before billing Medi-Cal.

Function of OHC
and COV Codes

The combination of the OHC and COV codes helps providers determine when to bill OHC before billing Medi-Cal. Refer to the following charts for more information.

**OHC and COV
Code Charts**

Use this chart to determine when to refer a recipient to an HMO or bill OHC before Medi-Cal. OHC and COV codes used in this table are described on the following page.

If the OHC code is ...	and the COV code is ...	Do the following
HMO coverage: C, F, K, P or 9 (or HMO coverage designated through any other code)	Is COMPREHENSIVE * or Includes the COV code for the claim form you use **	Refer recipient to HMO, or treat if you are a contracted provider with the HMO
	Does not include the COV code for the claim form you use	Treat patient and bill Medi-Cal
Cost-avoided coverage: B, D, E, G, H, I, J, Q, R, S, T, U, V, W, 2, 3, 4, 5, 6, 7 or 8	Is COMPREHENSIVE or Includes the COV code for the claim form you use	Treat patient and bill OHC or contact OHC for treatment authorization/denial
	Does not include the COV code for the claim form you use	Treat patient and bill Medi-Cal
Non-restricted coverage: A, L, M, N, X, Y, or Z	Is COMPREHENSIVE or includes the COV code for the claim form you use	Treat patient (OHC billing is encouraged, but not required)

* "Comprehensive": OHC billing is encouraged but not required for COV code "L".
** COV "L": If the recipient's scope of coverage includes COV code "L", refer the recipient to the HMO or treat if you are a contracted provider with the HMO.

Other Health Coverage (OHC) Codes Chart

OHC Code	Carrier	OHC Code	Carrier
A	Any carrier	T	Travelers Plan Administrators (only)
B	Blue Cross of California	U	CIGNA/Connecticut General/Equicor
C	Champus (HMO)	V	Coverage other than those specified (variable)
D	Prudential	W	Great West Life Assurance Co.
E	Aetna	X	Blue Shield of California
F	Medicare HMO	Y	Undefined
G	General American	Z	Blue Cross of California
H	Mutual of Omaha	2	HealthSource Provident Administrators
I	MetraHealth	3	Principal Financial Group/Principal Mutual
J	John Hancock Mutual Life Insurance	4	Pacific Mutual Life Insurance
K	Kaiser (HMO)	5	First Health/Alta Health
M	Multiple coverage (recipient has more than one insurance policy)	6	American Association of Retired Persons (AARP)
P	PHP/HMO	7	Undefined
Q	Undefined	8	New York Life Insurance
R	Undefined	9	Healthy Families (HF) Program
S	Blue Shield of California		

Scope of Coverage (COV) Codes Chart

COV Code	Service Category	Bill On (Claim Type)
P	Prescription Drugs/Medical Supplies	*Pharmacy Claim Form* **(30-1)** or CALPOS
L	Long Term Care	*Payment Request for Long Term Care (25-1)*
I	Hospital Inpatient	*UB-92 Claim Form*
O	Hospital Outpatient	*UB-92 Claim Form*
M	Medical and Allied Services	*HCFA 1500* claim form
V	Vision Care Services	*Payment Request for Vision Care and Appliances (45-1)*
D	Dental Services	Not applicable to EDS claims
Comprehensive	Coverage for all medical services except Long Term Care and dental	As appropriate

This section describes the required steps for billing Medi-Cal when a recipient also has OHC, Medicare and Medicare HMO. Refer to the *Other Health Coverage (OHC) Codes Chart* and *Other Health Coverage Guidelines for Billing* sections in the Part 1 manual for information about how to determine OHC beneficiary eligibility.

Medicare and OHC

When a recipient has both Medicare fee-for-service and cost-avoided OHC, the provider must bill:

1. Medicare for the Medicare-covered services, (do not bill as an automatic crossover claim) and

2. The OHC carrier

3. Medi-Cal last. Attach the Medicare *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN) and the OHC EOB to the Medi-Cal claim, except Pharmacy providers.

<u>Pharmacy Providers</u>

Pharmacy providers do not submit OHC attachments for electronic or hard copy claim submissions. For more information, see "Pharmacy: Self-Certification for OHC" in this section.

Note: If the OHC is a Medicare supplemental policy through an HMO, refer the recipient to the HMO.

Billing Medi-Cal After OHC

These principles must be followed when billing Medi-Cal after billing OHC:

- The OHC must be used completely.

- Medi-Cal may be billed for the balance, including OHC copayments, OHC coinsurance and OHC deductibles. Medi-Cal will pay up to the limitations of the Medi-Cal program, less the OHC payment amount, if any.

- Medi-Cal will not pay the balance of a provider's bill when the provider has an agreement with the OHC carrier/plan to accept the carrier's contracted rate as a "payment in full."

- An *Explanation of Benefits* (EOB) or denial letter from the OHC must accompany the Medi-Cal claim, except for pharmacy providers. Refer to "Pharmacy: Self-Certification for OHC" in this section.

- The amount, if any, paid by the OHC carrier for all items listed on the Medi-Cal claim form must be indicated in the appropriate field on the claim. Providers should not reduce the *Charge* amount or *Total Amount* billed because of any OHC payment. Refer to claim form completion instructions in this manual for more information.

OHC EOB or Denial Letter: Documentation Required by Medi-Cal

When billing Medi-Cal for any service partially paid or denied by the recipient's OHC, the OHC EOB or denial letter must accompany the claim and state the following:

- Carrier or carrier representative name and address

- Recipient's name or Social Security Number

- Date

- Statement of denial, termination or amount paid

- Procedure or service rendered

- Termination date or date of service

When a service or procedure is not a covered benefit of the recipient's OHC, a copy of the original denial letter or EOB is acceptable for the same recipient and service for a period of a year from the date of the original EOB or denial letter.

A dated statement of non-covered benefits from the carrier is also acceptable if it matches the insurance name and address and the recipient's name and address.

It is the provider's responsibility to obtain a new EOB or denial letter at the end of the one-year period. Claims not accompanied by proper documentation will be denied.

Pharmacy Providers

Pharmacy providers do not include OHC attachments with pharmacy claims since the entry of the OHC code on the claim self-certifies for the OHC requirement. Pharmacy providers must, however, be able to retrieve information received from a recipeint's OHC carrier. Refer to "Pharmacy: Self-Certification for OHC" in this section.

OHC Cost-Sharing

Providers are prohibited from billing Medi-Cal recipients, or individuals acting on their behalf, for any amounts other than the Medi-Cal copayment or Share of Cost (SOC).

Therefore, if the recipient's OHC requires a copayment, coinsurance, deductible or other cost-sharing, the provider is not permitted to bill the recipient. If the provider bills the OHC and the OHC denies or reduces payment because of its cost-sharing requirements, the provider may then bill Medi-Cal. Medi-Cal will adjudicate the claim, deducting any OHC payment amounts.

When to Bill OHC

Refer to the chart in the *Other Health Coverage (OHC) Codes Chart* section of the Part 1 manual to determine when to bill OHC.

Delayed Insurance Response

If a response from the OHC carrier is not received within 90 days of the provider's billing date, providers may bill Medi-Cal. A copy of the completed and dated insurance claim form must accompany the Medi-Cal claim. State "90-day response delay" on the attachment.

Medi-Cal Remittance Advice Details (RAD)

OHC billing information is included on the Medi-Cal *Remittance Advice Details* (RAD) when a claim is denied because the provider did not include proof of insurance billing with the Medi-Cal claim.

If available, the OHC information provided will include the insurer's name and billing address and the policyholder's Social Security Number. This information helps providers billing OHC. For more information, refer to the Remittance Advice Details (RAD) examples and *Remittance Advice Details (RAD): Payments and Claim Status* sections in this manual. For general RAD information, refer to the *Remittance Advice Details (RAD) and Medi-Cal Financial Summary* section in the Part 1 manual.

**HMO Denial
Letters**

EDS often receives HMO denial letters containing the statement: "HMO eligible, but services were not rendered by an HMO facility/provider; therefore, patient is not eligible for HMO benefits." This is not an acceptable denial letter because the recipient did not exhaust the HMO coverage.

In order to establish Medi-Cal liability to pay claims for a recipient with HMO coverage, the provider must obtain a denial letter or EOB that clearly states one of the following:

- The recipient's HMO coverage has been exhausted, or

- The specific service is not a benefit of the HMO.

**Kaiser Denial
Letters**

Providers billing Medi-Cal for Kaiser non-covered services must attach a specific denial letter from Kaiser (see sample on a following page). Denial reasons 2, 5 and 8 are not acceptable.

Although the directive in item 8 of the Kaiser denial letter states that providers should bill the patient directly, providers are reminded that State law prohibits them from billing Medi-Cal recipients.

Note: Kaiser facilities billing Medi-Cal for services that are not benefits of Kaiser must also include a statement with the claim containing the required denial information. A rubber stamp is acceptable only if it provides spaces to fill in the required information, directly relating it to the claim form submitted.

<div style="text-align: center">**On Kaiser Letterhead**</div>

Provider Name and Address:

Date:
Kaiser Plan No.:

RE:
DATE(S) OF SERVICE:
TYPE OF SERVICE:

We are unable to consider payment for the above service you rendered for the following reason(s):

___ 1.   The person named above was not covered by our Plan at the time of service.

___ 2.   Our members are not covered for non-emergency services obtained from non-Plan providers. All services except certain emergency care must be obtained from Plan facilities and physicians.

___ 3.   Our members are not covered for the type of service specified above. This service is a contractual exclusion of our plan.

___ 4.   The person named above is not covered by our prescription drug benefit.

___ 5.   Prescriptions purchased at non-Plan pharmacies are not covered by our prescription benefit.

___ 6.   The item purchased is not covered by our prescription drug benefit.

___ 7.   The person named above does not have coverage for eyeglasses or contact lenses.

___ 8.   Please bill the patient directly. Kaiser Foundation Health Plan will consider reimbursement only for emergency care and only when our member requests reimbursement through our Out-of-Plan Claims procedure.

___ 9.   We are unable to identify the above person as a member of our program.

___ 10. Other: _____

_____

_____

_____

KAISER FOUNDATION HEALTH PLAN, INC.

SERVICE REPRESENTATIVE

<div style="text-align: center">Sample Kaiser Denial Letter.</div>